MDR: M4-02-1782-02

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 01/25/01?
   b. The request was received on 01/25/02.

II. EXHIBITS

1. Requestor, Exhibit 1:

   a. TWCC 60
   b. HCFA's/UB-92 1450
   c. EOB
   d. Medical Records
   e. Letter dated 05/25/01 explaining Carrier's methodology
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit 2:

   a. TWCC 60
   b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. According to the TWCC MDRIS computer system, the provider's initial request was received in the Austin Medical Review Division on 01/25/02. The 3 day response for the Carrier was 01/28/02. The Division sent the 14 day letter to the Requestor, requesting additional information on 03/29/02. To date the additional information has not been received in the Austin Division.

III. PARTIES' POSITIONS

1. Requestor:
   Additional reimbursement is sought in the amount of $1,695.18 for date of service 01/25/01.

2. Respondent:
   The Carrier had no 14 day response as indicated above.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 01/25/01.

2. The Provider billed $2,439.24 for the date of service 01/25/01.

3. The Carrier paid $744.06 for the date of service 01/25/01.

4. The amount in dispute per the TWCC-60 is $1,695.18.

5. The carrier has denied additional reimbursement for the date of service 01/25/01 as "M-No MAR/ASC reimbursement is based on fees established to be fair and reasonable in your geographical area."

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgical center. Commission Rule 134.401 (a) (4) states ASC(s) "…shall be reimbursed at a fair and reasonable rate…"

Texas Labor Code Section 413.011 (d) states, "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

The Medical Fee Guidelines General Instructions (VI) discuss that if a MAR value has not been established for a CPT code, reimbursement shall be, "…at the fair and reasonable rate."

Because there is no current fee guideline for ASC(s), the health care provider has the burden to prove that the fees paid by the carrier were not fair and reasonable. The provider failed to meet the criteria of 413.011 (d). Therefore, no reimbursement is recommended.

The above Findings and Decision are hereby issued this 10th day of June, 2002.

Michael Bucklin, LVN
Medical Dispute Resolution Officer
Medical Review Division
MB/mb

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.